TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EZ SCRIPTS LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-0041-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 9, 2020

REQUESTOR'S POSITION SUMMARY

"We are not contracted with Optum, Tmesys, or Cypress Care but we were paid at the in-network rate."

Amount in Dispute: $358.16

RESPONDENT'S POSITION SUMMARY

"Upon review of the explanation of benefits for the pharmacy Mail My Meds/EZ Scripts, the bill and payment was made in accordance to Cypress Care Contract … Texas Mutual does not access information regarding contracts as that is proprietary information, therefore the carrier cannot address the dispute."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2019	Cyclobenzaprine HCl 10 mg	$119.83	$119.83
September 3, 2019	Tramadol HCl 50 mg	$39.50	$39.50
September 9, 2019	Tramadol HCl 50 mg	$39.50	$39.50
September 13, 2019	Tramadol HCl 50 mg	$39.50	$39.50
October 29, 2019	Cyclobenzaprine HCl 10 mg	$119.83	$119.83
	Total	$358.16	$358.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Codes §§134.530 and 134.540 set out the preauthorization requirements for

pharmaceutical services.

4. Texas Labor Code §408.0281 sets out the requirements for informal networks for pharmaceutical services.
5. Texas Insurance Code, Chapter 1305 sets out the requirements for certified healthcare networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

   For dates of service September 3, 2019 – September 13, 2019:

   - CAC-18 – Exact duplicate claim/service
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 715 – Service previously billed with different/incorrect codes, provider, claim, etc. Processed as correction only-no addtnl payment
   - 877 – Bill previously processed. Refer to Rule 133.250 regarding request for reconsideration.
   - 891 – No additional payment after reconsideration.

   For date of service October 29, 2019:

   - CAC-131 – Claim specific negotiated discount.
   - PC4 – Payment reduced to Cypress Care contract rate.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Is the payment of the drugs in question subject to network reduction?
2. Are the insurance carrier's reasons for reduction of payment based on billing with different/incorrect codes, provider, or claim supported?
3. Is EZ Scripts, LLC entitled to additional reimbursement?

Findings

1. EZ Scripts, LLC is seeking additional reimbursement dispensed September 3, 2019 through October 29, 2019. Documentation submitted by the requestor indicates that the Texas Mutual Insurance Company reduced payments to a total of $14.44 based on a contract amount.

   Prescription medication may not directly or indirectly be delivered through a workers' compensation health care network.[1] No evidence of an informal network[2] between the pharmacy and the insurance carrier or their agents was provided. Therefore, the DWC concludes that payment of the drug in question is not subject to network reduction.

2. Texas Mutual Insurance Company also reduced the drugs in question based on billing with different/incorrect codes, provider, or claim. No evidence was presented to related to this denial. The DWC finds that this denial reason is not supported.

3. Because Texas Mutual Insurance Company failed to support its denial reasons for the service in this dispute, the DWC finds that EZ Scripts, LLC is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[3]:

   - Cyclobenzaprine HCl 10 mg tablets: (1.09149 x 90 x 1.25) + $4.00 = $126.79 per date of service. EZ Scripts, LLC billed $123.30 for each date of service for this drug.
   - Tramadol HCl 50 mg tablets: (0.83289 x 40 x 1.25) + $4.00 = $45.64 per date of service. EZ Scripts, LLC billed $42.00 for each date of service for this drug.

[1] TIC §1305.101 (c)
[2] TLC §408.0281
[3] 28 TAC §134.503 (c)

The total allowable reimbursement is $372.60. Texas Mutual Insurance Company paid $14.44. EZ Scripts, LLC requested an additional payment of $358.16. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $358.16.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $358.16, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 31, 2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.